NOTE: Complete this page for ALL annual reports.

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825

PUBLIC SELF INSURER'S ANNUAL REPORT FOR NON-JPA MEMBER

I. GENERAL

1. CERTIFICATE NUMBER: ☐-☐☐☐☐-☐☐-☐☐☐

☐ Active ☐ Revoked

2. PERIOD OF REPORT:

☐ Full Year ☐ Interim Report for the Period of:

☐☐ ☐☐ ☐☐☐☐ Month Day Year to ☐☐ ☐☐ ☐☐☐☐ Month Day Year

3. NAME OF MASTER CERTIFICATE HOLDER:

_____

Federal Tax Identification No.: _____

_____

Address of Main Headquarters

_____

CITY STATE ZIP + 4

4. TYPE OF PUBLIC AGENCY:

☐ CITY/COUNTY ☐ POLICE/FIRE ☐ TRANSIT
☐ SCHOOL ☐ HOSPITAL ☐ OTHER

5. During the period of this report, has there been any of the following with respect to the master certificate holder, subsidiary or affiliate certificate holder?

A merger or unification?	☐ Yes	☐ No
Change in name or identity?	☐ Yes	☐ No
Any addition to Self Insurance Program?	☐ Yes	☐ No

If yes, explain: _____

_____

6. Are there any agency employees NOT included in your Workers' Compensation Self Insurance Program?

☐ Yes ☐ No

If yes, what employees are not included? _____

_____

Are these employees covered by an insurance policy?	☐ Yes	☐ No
Are these employees covered by another self insurance cert. or JPA?	☐ Yes	☐ No

7. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE: _____

AGENCY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP + 4: _____

TELEPHONE: ( ) _____ FACSIMILE (FAX): ( ) _____

8. CERTIFICATION BY AGENCY OFFICIAL:

I declare under the penalty of perjury that I have examined this Self Insurer's Annual Report and to the best of my knowledge and belief it is true, correct and complete.

Signature (Original Only): _____ Date: _____

Typed Name: _____

Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4: _____

Telephone: ( ) _____ Facsimile (FAX): ( ) _____

ANNUAL REPORT IS DUE OCTOBER 1, 1997

***NOTE:* Claims Administrator**
Complete this page for ALL reports except item B Employment/Wages, which is completed by Self-insured employer.

II. CONSOLIDATED LIABILITIES

Certificate Number: ☐-☐☐☐☐-☐☐-☐☐☐

Name of Master Certificate Holder: _____

Type of Report:

☐ **Original** Report (Due October 1 each year)

☐ **Amended** Report:
From Date: ☐☐ Month ☐☐ Day ☐☐ Year To Date: ☐☐ Month ☐☐ Day ☐☐ Year

A. CASES AND BENEFITS (to nearest dollar)

		Incurred Liability		Paid to Date		Future Liability	
	Number	$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 6/30/97 reported prior to FY 1992-93							
2. Open & Closed Cases:							
a. FY 1992-93 Total cases reported							
FY 1992-93 Cases open							
b. FY 1993-94 Total cases reported							
FY 1993-94 Cases open							
c. FY 1994-95 Total cases reported							
FY 1994-95 Cases open							
d. FY 1995-96 Total cases reported							
FY 1995-96 Cases open							
e. FY 1996-97 Total cases reported							
FY 1996-97 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
TOTAL		

3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)

$ Indemnity	$ Medical

4. Total Benefits paid during FY 1996-97 (include all case expenditures): . . . . . .

5. Number of MEDICAL-ONLY cases reported in FY 1996-97: . . . . . _____

6. Number of INDEMNITY cases reported in FY 1996-97: . . . . . _____

7. TOTAL of 5 and 6 (also enter in 2e above): . . . . . _____

8. TOTAL number of open indemnity cases (all years): . . . . . _____

9. Number of Fatality cases reported in FY 1996-97: . . . . . _____

10. (a) Number of FY 1996-97 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1996-97: _____

(b) Number of new applications for adjudication received for any claim year during FY 1996-97: . . . . . _____

B. TOTAL EMPLOYMENT AND WAGES PAID IN FISCAL YEAR 1996-97 FOR THIS SELF INSURER:

(a) NUMBER OF EMPLOYEES*_____
(Number of individual employees listed on Form DE 6 for year ending June 30, 1997)

(b) TOTAL WAGES AND SALARIES PAID* $_____

***NOTE:* Use total number of separate employees reported to Employment Development Department (EDD) on Quarterly Report Form, DE 6, if applicable, regardless of length of employment during the year.

IIA. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

2. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

3. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

4. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THIS REPORTING PERIOD? ☐ **YES** ☐ **NO** **IF YES, DATE OF CHANGE:** ☐☐☐☐☐☐ (Month Day Year)

TYPE OF CHANGE: ☐ **Change in Administrative Agency**

☐ **Change to or from Self Administration**

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ **State** ____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgement as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____

Original Signature of Administrator (Person) **Date**

_____ _____

Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____

Title **Street Address**

_____

City **State** **Zip+4**

Phone No. of Administrator (**)** _____ **FAX No. (** **)** _____

area code **area code**

***NOTE:* Claims Administrator**
Complete this page for ***each adjusting*** *location where there are at least two adjusting locations.*

III. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.: ☐-☐☐☐☐-☐☐-☐☐☐

Name/Identification of Location: _____
OR
Name of Affiliate/Subsidiary Certificate Holder: _____

Type of Report:

☐ **Original** Report (Due October 1 each year)

☐ **Amended** Report:
From Date: ☐☐ Month ☐☐ Day ☐☐ Year To Date: ☐☐ Month ☐☐ Day ☐☐ Year

A. CASES AND BENEFITS (to nearest dollar)

		Incurred Liability		Paid to Date		Future Liability	
	Number	$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 6/30/97 reported prior to FY 1992-93							
2. Open & Closed Cases:							
a. FY 1992-93 Total cases reported							
FY 1992-93 Cases open							
b. FY 1993-94 Total cases reported							
FY 1993-94 Cases open							
c. FY 1994-95 Total cases reported							
FY 1994-95 Cases open							
d. FY 1995-96 Total cases reported							
FY 1995-96 Cases open							
e. FY 1996-97 Total cases reported							
FY 1996-97 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical) TOTAL		

$ Indemnity	$ Medical

4. Total Benefits paid during FY 1996-97 (include all case expenditures): . . . . . .

5. Number of MEDICAL-ONLY cases reported in FY 1996-97: . . . . . _____

6. Number of INDEMNITY cases reported in FY 1996-97: . . . . . _____

7. TOTAL of 5 and 6 (also enter in 2e above): . . . . . _____

8. TOTAL number of open indemnity cases (all years): . . . . . _____

9. Number of Fatality cases reported in FY 1996-97: . . . . . _____

10. (a) Number of FY 1996-97 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1996-97: _____

(b) Number of new applications for adjudication received for any claim year during FY 1996-97: . . . . . _____

IIIA. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) AT THE TIME OF PREPARING THIS REPORT**.**

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ **YES** ☐ **NO** **IF YES, DATE OF CHANGE:** ☐☐☐☐☐☐ Month Day Year

TYPE OF CHANGE: ☐ **Change in Administrative Agency**

☐ **Change to or from Self Administration**

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ **State** ____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgement as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____

Original Signature of Administrator (Person) **Date**

_____ _____

Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____

Title **Street Address**

_____

City State Zip+4

Phone No. of Administrator ( ) _____ **FAX No. ( )** _____

area code **area code**

IV. RECORDS STORAGE

1. Are claims records stored at any location other than with the current administrator?

☐ **Yes** ☐ **No** **If yes, Where?** _____

A. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

B. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

C. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

D. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

VI. OPEN INDEMNITY CLAIMS

A. List of *ALL* Open Indemnity Claims by reporting location and by year reported and with claims in alphabetical order is attached immediately following page 6 of this report.
(You may use the form attached or a computer-prepared printout organized in the same format.)

VII. FUNDING OF LIABILITIES

Certificate Number: ☐-☐☐☐☐-☐☐-☐☐☐

Name of Certificate Holder: _____

_____

1. Which of the following best describes the method your agency uses to fund the outstanding workers' compensation liabilities?

- ☐ Actuarial Basis
- ☐ Cash Flow Basis
- ☐ Fixed Amount in Agency Budget—Amount is: $ _____
- ☐ Percentage Above Last Year's Losses—Percentage is: _____ %
  —Total Amount Available is: $ _____
- ☐ Agency Does Not Fund Workers' Compensation Liabilities
- ☐ Other: _____

2. Does your agency fund for incurred but not reported workers' compensation claims in addition to known or reported claims?

☐ Yes ☐ No If yes, Amount: $ _____

3. Is the workers' compensation funding restricted or set aside solely to pay the agency's workers' compensation liabilities?

☐ Yes ☐ No

If yes, what was the amount set aside as of June 30, 1997? $ _____

4. Does your agency have an outside, independent claims auditor review your case reserve practices and general claims management?

☐ Yes ☐ No

If yes, what was the date of the last such audit? _____

5. Does your agency have an outside, independent actuary to review future liability funding?

☐ Yes ☐ No

If yes, what was the date of the last such review? _____

Page ____ of ____ Pages

LIST OF OPEN INDEMNITY CASES

AS OF _____

(Date)

Reporting Location No.: _____

Certificate Number: _____

All Cases on this Page are

For the Year _____

NAME OF MASTER CERTIFICATE HOLDER: _____

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Labor Code Section 4850 Salary	Description of Injury	Paid to Date		Estimated Future Liability	
				$ Indemnity	$ Medical	$ Indemnity	$ Medical
(List Alphabetically within year)							